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ABSTRACT

This paper explores the barriers and possible solutions toward the implementation of the goal of a coordinated service system for young children with special needs and their families. The components of the vision of a comprehensive, interagency, multidisciplinary, coordinated service system are outlined, such as interdisciplinary cooperation, a significant family role, and services for all eligible children. A table lists some of the grounding assumptions in the health, special education, and social services professions. The paper discusses whether change called for by Part H of the Individuals with Disabilities Education Act should be revolutionary, which would attack these grounding assumptions, or evolutionary, which would preserve the grounding assumptions. The paper then considers how the actual implementation of the vision would vary by context, how the steps necessary to move from the current system to the new vision must be determined, and how to develop strategies by which appropriate resources are obtained for the new vision. (Contains 36 references.) (JDD)

THE IMPLEMENTATION OF A VISION OF COMPREHENSIVE SERVICES

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One of the outstanding challenges to policy development and policy implementation is how to blend diverse systems of care for the full benefit of children with disabilities and their families. Two pieces of federal legislation address the need for collaborative efforts to build a system of care for children with special needs: Part H of the Individuals with Disabilities Education Act (IDEA) and Title V of the Social Security Act (The Maternal and Child Health Block Grant). Part H of IDEA requires each cooperating state to develop and implement a statewide "comprehensive, coordinated, multidisciplinary, interagency program of early intervention services."

Both Part H of IDEA and Title V of the Social Security Act stress family empowerment, with Part H requiring an Individual Family Service Plan. Both laws also encourage a multidisciplinary approach that can involve as many as 11 different professions and numerous state agencies. The purpose of this chapter is to explore the barriers and possible solutions toward the implementation of the goal of a coordinated service system.

For many years, several major systems of care have existed relatively separate from one another. Three such major systems that we can readily observe are: the health system, the social service system, and the education system. Actually, it is straining reality to refer to these enterprises as "systems," because neither of them fits the traditional definition of "system." Hutchins (1992) has pointed out that one of the major problems of the health enterprise is its inability to organize itself in a systematic manner. The health enterprise, as it currently stands, maintains major elements in both the private sector and the public sector; its various authorities for action are scattered among various federal and state levels to include primary, secondary, and tertiary care.

The social welfare enterprise has focused its energy into helping those who have had trouble in adapting to the society. Through counseling and the search for better environmental conditions, the social work enterprise tries to neutralize negative forces impacting on many children and families in our society.

The public educational enterprise includes over 14,000 local autonomous school districts, with each of the 50 states taking responsibility for various professional standards as well as significant financial support. The federal government contributes special program support for economically disadvantaged students and children with disabilities, but mainly is supporting a research, development, demonstration, and dissemination function designed to stimulate--but not to administer or direct--state and local educational programs.

It is also worth noting that each of these enterprises targets a different population of children. The health community is concerned with a variety of acute and chronic illnesses that they attempt to cure or ameliorate. A small amount of their resources is spent on preventing disorders or of enhancing the quality of life of children. The social services community has traditionally focused upon economically disadvantaged citizens and those children and adults whose lives run counter to the standard expectations and rules of the society. The education enterprise has the responsibility for all of the children within its traditional age spans--although there are some subdivisions of the

educational enterprise (e.g., special education, children with special needs) whose purposes often overlap somewhat with the other two systems.

The public policies that established and extended each of these systems were initiated at different times, with different purposes, and for different target populations. At the state and local community levels, there have been various governmental agencies assigned to administer the wide array of policies that emerged to support each of the major societal purposes for the three areas. It is little wonder, therefore, that when a call is made to integrate these systems in order to provide collaborative services to families, the task becomes one of striking complexity.

The complexity of the structures and programs that we wish to integrate is impressive in its own right, but we should not delude ourselves that complexity is the only reason why certain cooperative or collaborative efforts are slow to develop. There remains a major factor of self-interest that inhibits the easy collaboration between the three enterprises. One bureaucrat, when asked whether he was interested in cooperating with another agency, said that, "It all depends on whether we are going to cooperate them, or they are going to cooperate us." Such a frank admission is infrequently made. Many rationalizations have often been provided for not changing the status quo, rationalizations that have disguised the strong self-interests behind decision-making (Gallagher, 1992).

The growth of the family empowerment movement is one reason for the cry for interagency cooperation and multidisciplinary service programs. Service delivery, from the viewpoint of the professional disciplines, is primarily those services that each discipline has to offer: *health* services from *health* personnel, *educational* services from *educators*, etc. But, from the viewpoint of the child and family, it is easy to see that an assortment of cross-disciplinary resources is necessary in order to provide full and appropriate services. If one starts from the child and his/her problems, multidisciplinary cooperation becomes a clear necessity. The emergence of the role of case manager, or service coordinator, is a recognition of the need to orchestrate resources across a number of diverse service personnel. It seems apparent that the perception of the appropriate role of the case manager varies substantially from the health to the educational community. That is one example of the difficulty of blending these various service systems together (Fullagar, Crotser, Gallagher, Loda, & Shieh, 1991). In order to design and implement some type of new collaborative service system, we will need to take cognizance of past efforts to accomplish similar goals and their successes and problems.

A Vision and Its Implementation

The vision of a comprehensive, interagency, multidisciplinary, coordinated service system for all infants and toddlers with disabilities and their families clearly lay behind the legislation we refer to in the present text as Part H of IDEA. A "vision" in the dictionary sense is "something seen otherwise than by ordinary sight" or "unusual discernment or foresight." The creators of this legislation "saw," in their imagination, a comprehensive service system that does not now exist.

The components of the vision seem clear. There should be cooperation from many disciplines in the delivery of services. Families should have a significant role in the design of the program for their own child and a voice in the overall policies related to the law. All eligible children and their families should be served, not just a few families who have enough personal resources or who are in a favorable geographic proximity to available services. There was a hope that children who are "at risk" for disabilities at a young age should also be provided assistance to prevent the further development of unfavorable consequences due to their "at risk" condition.

Yet visions of this sort need to be drawn into the reality of service delivery and professional practice if they are to become meaningful. Think about other grand visions, such as "universal disarmament," "love thy neighbor," or "a job for all who wish one." It is clear that visions, unattached to practical steps to implement them, become mere exercises in imagination. What needs to be done is to bring ideas such as "multidisciplinary coordination" into some form of concrete representation. To accomplish this exercise in implementation, three major questions need to be posed and answered.

Such a vision should include the following components:

1. How should a multidisciplinary interagency service system operate in state X?

What should be the various components of the system? How should they interact with one another? What lines of authority and responsibility should be established? How should clients traverse the system?

2. How can we move the current policies and procedures from the status quo to the new vision?

This stage requires special knowledge of the existing service enterprises, of lines of influence and authority in state government; an understanding of the political forces at work in the states, and of how laws and regulations can be written to result in the new model's having an appropriate governmental structure.

3. How can we find the resources necessary to support the new service system?

Finally, without adequate financial, personnel, or administrative resources, the new system will remain a "paper product," unable to bring the new system into reality.

The implementation of the Part H vision can be constructed by one dynamic or charismatic individual, or by a small group of individuals working together. It then must be "sold" to others before major policy changes can take place.

Grounding Assumptions

In Part H of IDEA, are we in for just another set of small adjustments and fine-tuning for the existing service systems, or are we asking for a major reorientation? That question may well be answered differently by different persons. One issue is whether a relatively small program (in terms of financial resources) such as Part H can really create the major changes in professional services and structure for which the law seems to call.

Table 1 provides some of the grounding assumptions of several professions engaged in programs to aid infants and toddlers with disabilities. The authors of the Part H legislation clearly were intent on attacking the grounding assumptions of some of the practices now abroad. They no longer wanted treatment to be partitioned into various professional disciplines. They no longer wanted a "doctor knows best" approach to families–whether that doctor is a pediatrician, a psychologist, or a nutritionist. So this is not just an attempt to remediate minor administrative processes, but a desire to change the fundamental relationships between professionals and between professionals and families.

Table 1 gives one version of the grounding assumptions in health, special education, and social services. One of those assumptions implicit in each profession is that only these specific professionals can do the work effectively, with only minor contributions from other professions. The assumptions of Part H are quite different. In this law, the assumption is that substantial professional teamwork is needed to draw up a treatment plan, and substantial collaboration is necessary to carry out the IFSP.

Revolutionary Change vs. Evolutionary Change

One question that will not be answered until the states have "fleshed out" their various programs is whether this legislation, as implemented, is revolutionary or evolutionary in character. In this context, we take "revolutionary" to mean actions that attack the grounding assumptions of a program or discipline, rather than those that attempt to remediate the status quo. Revolutionary here does not necessarily imply a huge, societal-level shift. The term "revolutionary" can apply to a new way of preparing broccoli, producing a play, or choosing a mate. One can, on the other hand, change the balance of power in American government or redefine the family. What is required to be properly called "revolutionary" is that the new way attacks the fundamental assumptions under which the old way was performed.

Table 2 provides some examples of an evolutionary versus revolutionary approach in several familiar areas. The importance of making this distinction is considerable. If the effort is viewed as revolutionary, then the leadership strategies and approaches needed to carry out the changes are quite different from the skills needed to make minor adjustments. For one thing, initiators of change will need considerable persuasive powers to convince others that major changes are needed. Tushman and Romenelli (1985), in their studies of organizations, refer to long periods of convergence (small improvements on existing practices) punctuated by periods of reorientation requiring

Table 1

Grounding Assumptions of Various Professions

HEALTH

1. There is a wide range of diseases or conditions that affects young children who need to be treated.
2. A physician, through the use of a variety of tools and specialists, can determine the diagnosis of the disease and condition.
3. With appropriate diagnosis, the physician and the team of health specialists are able to design an appropriate treatment to cure or ameliorate the condition.
4. For chronic conditions needing ancillary services, the physician (pediatrician) can refer the family to other appropriate professionals.

SPECIAL EDUCATION

1. Disabilities are pathological conditions that some children have.
2. Differential diagnosis is objective and useful.
3. Special education is a rationally conceived and coordinated system of services that benefits diagnosed students.
4. Progress results from incremental technological improvements in diagnosis and in instructional interventions.

SOCIAL SERVICES

1. There are individuals and families who are living in a set of environmental circumstances that can be physically and mentally unhealthy for them.
2. Careful analysis of the family and ecological factors through family interviews and document analysis will identify areas where improvements can be made.
3. Through the receipt of family counseling and the creation of improved environmental conditions, family members will be able to cope with their problems more effectively.
4. Social services will maintain continuing contacts with the family to ensure that the improvements remain and increase.

Table 2

CHANGE – EVOLUTIONARY VERSUS REVOLUTIONARY

Evolutionary (Preserving Grounding Assumptions)	**Revolutionary** (Attacking Grounding Assumptions)
We need to design better tests of intelligence to assess young children.	The concept of testing is outmoded and discriminatory and should be scrapped.
The diagnostic/prescriptive model needs to be applied more consistently by well trained persons.	The diagnostic/prescriptive model is inappropriate for use with families of young children. Treatment should begin immediately.
We need to improve our professional preparation programs in each of the disciplines.	A new interdisciplinary model of personnel preparation should take the place of the old training.
Professionals need to learn additional skills for interviewing parents, particularly parents from cultures different from themselves.	A community ombudsman should be the communication link between professionals and culturally different families.

considerable executive leadership to help the organization through major shifts in strategies, power, structure, and controls.

As Kochanek (1992) points out in his chapter, the vision of a comprehensive and integrated service system often lies in the imaginations of policy makers rather than in the experiences of those who must implement such visions. A few of the problems to be overcome from Kochanek's viewpoint are: agency rigidity, absence of leadership, protection of turf and power, competition for finite financial resources, and conflicting state and federal policies. Can this new system be initiated without incurring so much potential pain and suffering that it "turns off" the very people whose support will be necessary to make it work? That is the substantial challenge for "leadership without power" which describes the ecological context for Part H.

I. The Context and the Vision

The actual implementation of a vision of what a comprehensive, multidisciplinary service system for infants and toddlers with disabilities should be is likely to vary considerably by context. Whether the setting or context is urban, suburban, or rural, the components of the service system, such as the child-find operation, the clients entry into the system, the planning meetings to design an Individual Family Service Plan (IFSP), the case management decisions, the actual treatment program, and the follow-up and evaluation, should look considerably different across settings (see Figure 1). In the urban area, there are likely to be a large number of potential clients for these services, but potential problems in terms of transportation–of getting the client to the services if he or she has no automobile and must travel on two or three buses or subways to reach the treatment center. There may have been a flight of professionals away from the central urban area if the area has become economically depressed and, in some cases, dangerous.

The suburban areas would seem the most likely to be able to provide the service system that has been visualized by the authors of this legislation. In suburban areas, there is a variety and sufficiency of professionals and middle- to upper-class families who are capable of finding services and utilizing them most effectively. The rural areas, however, may be faced with a shortage of some technical personnel, and serious problems of transportation for many economically disadvantaged families. The actual distances that must be traversed by either the clients or by the professionals becomes a serious hindrance to the design of an effective service system for all families (Magrab, 1992).

The elements of a service system. Although current laws separate youngsters and families according to the age of the child (Part H dealing only with children from birth until three years of age and Section 619 dealing with youngsters from age 3 to 5), it is unlikely that such a division will be made in the practice of individual professionals (pediatricians, psychologists, speech-language pathologists, etc.). In such a practice, there would be no specialization on such a narrow age-range; the professional would wish to continue seeing the patient or client beyond the artificial division lines of age drawn by legislation (Coleman & Gallagher, 1990).

Figure 1

STRUCTURE OF VISION

System Components	Urban	Suburban	Rural
Child Find			
System Entry			
IFSP Development			
Case Management (Service Coordination)			
Personnel Preparation			
Treatment			
Follow-Up & Case Evaluation			

Some of the specific components of the vision include:

Child find. The Child Find system will likely adopt a variety of methods to match the cultural diversity of the client population itself. Some families may be able to use a telephone number flashed on the bottom of the television screen to seek out help, but others may have to be encouraged by friends and neighbors. It is in the area of economic disadvantage and cultural difference where a child-find system will have its greatest challenge (Arcia, Gallagher, & Serling, 1991). Decisions still awaiting determination in the implementation of policy include who will conduct the child-find system and what will happen to the child once he or she has been found.

System entry. How the client gains entry to the system can vary widely. The client must be convinced that the service system will bring tangible benefits sufficient to overcome the inconveniences involved. Not all families are ready to commit to services, and how they can be convinced of the benefits of the services is an essential part of the treatment sequence, along with the specific steps the families must take to enter the comprehensive service system.

IFSP. The use of a team of professionals to design an Individual Family Service Plan (IFSP) in collaboration with the family is another part of the Part H vision of implementation. The actual development of an IFSP, too, will likely look very different in the various geographic contexts. It is likely that there would be some central place, a clinic, school, or group practice, where the appropriate professionals could assemble to help design, with the participation of the family, a comprehensive treatment program for the child. Again, who will lead the discussions and who will participate will vary according to the child's needs and the context.

Case management (service coordination). Another significant element in the Part H vision involves the decisions related to case management or service coordination (Fullagar, Crotser, Gallagher, Loda, & Shieh, 1991). The term "case manager" has been replaced with "service coordinator" based upon some parents' complaints that they didn't consider themselves "cases" and certainly didn't wish to be "managed." The concept of service coordination in the Part H law is that the family should have one consistent point of contact, even if they and their child are receiving treatment from four or five different professionals. Furthermore, the team of professionals needs to have a professional who understands and works with the entire case, rather than just on the child's hearing, muscle tone, or cognitive development. Who will play the role of service coordinator may well vary from one context to another.

There are two significant roles potentially played by such a service coordinator. One is that of decision maker in determining the direction of the treatment program–always with the help and assistance of others. The second is a more logistics-oriented role. This person would be a scheduler who keeps in touch with the family, organizes group meetings, and calls for a review of the case periodically. Clearly, service coordination has elements of executive decision-making and also logistical management of the case itself in its daily and weekly progress.

Personnel preparation. A significant part of the vision of a comprehensive service system has to involve the issues of who is going to deliver the needed services, and what standards need to be established across disciplines to ensure quality service delivery. Part H requires the states to report on personnel standards and to inform the federal government of how they plan to meet the personnel requirements.

Treatment. The treatment program will also, naturally, vary by context. There is not always a physical therapist available when needed, nor a psychologist trained to work with families. Even if the child and family need a diversity of professional contact, some of the services may have to be either not delivered, or be delivered by someone other than the standard professional. For example, some form of physical therapy may have to be given by an early childhood interventionist because a physical therapist may not be available.

For children with multiple disabilities, the treatment program is likely to be a long progression of contacts, where the goal is not so much cure as it is amelioration. The seriously involved child and his or her family are likely to be in some form of professional context for the greater part of the life of the child–certainly until the child reaches maturity. This, too, represents a case management decision; what happens when the child goes through a significant transition period, such as entering the public school system?

Follow-up & case evaluation. Finally, in such a comprehensive service system, there is the responsibility for a systematic follow-up and case evaluation. The busy professional is likely not to notice the disappearance of a particular client if he/she is busily engaged in a heavy practice. Some form of data system that tracks clients would seem to be necessary not only for the purposes of state reporting, analysis, and planning, but also to make sure that families and children do not "disappear" through their chronic failure to come for treatment. A system that is continually improving needs to establish a systematic way of reviewing and assessing the effectiveness with which cases were treated and the desirability of the outcomes achieved (Bachrach, 1989).

The Venue of Care

One of the significant issues to be determined in the design of a comprehensive system of care is where such a system should be placed, geographically and professionally. Two of the authors in the present volume have a clear vision of where such a system should be placed–in the health area. Walker (1992) gives her rationale as follows:

> Since the health care system is the only one with which all parents should have interaction from the birth of their child through the child's third birthday, it conceptually makes sense to design an early intervention system that is integrated and embedded in the primary health care system in a community.

Shonkoff (1992) warns against the development of two separate service systems operating in parallel to one another, one in the health field and one in the social field. He calls for a new, unified service system that reflects the best

of both pediatric health care and early childhood intervention. While Shonkoff sees the need for transformation of both systems, he does see the entry point of the system through the health services.

Whether such a system can be designed in the egalitarian manner that Shonkoff wishes, or whether some of the team members (e.g., physicians) who traditionally have held more authority than other professionals will reproduce that earlier relationship remains to be seen, but it certainly is a potential source of conflict in the design of the system (Gray & Hay, 1986). It is the issue of reciprocity (relatively equal distribution of power) vs. asymmetry (an unbalanced distribution of power) that is being determined here.

Some observers (Stevens, 1989; Kiesler, 1992) have noted that one of the strengths of the American health system, the community hospital, does not match up well with the health needs of the nation. The hospital is designed to conduct short-term acute care, often accompanied by surgery. As Kiesler (1992) points out:

> Left underemphasized in U.S. health policy are: preventative services needed by the least wealthy 40% of the population; the needed behavioral changes in the population that could lead to healthier practices; and various chronic health problems especially those experienced by the elderly, children, and youth. (p. 1077)

It is these chronic health problems, of course, that are the central focus of health care for infants and toddlers with disabilities.

An alternative model, which has been developed in a number of states, provides early intervention services from a combination of disciplines representing the social sciences (education, psychology, social work, etc.). In such a model, the emphasis is upon early intervention for the child with disabilities and social services and counseling for the families. The health services are viewed as ancillary and brought into the picture as consultants whenever needed for particular children and families (see, for example, Palsha, et al., 1990).

Each of the models presented above can be fairly referred to as asymmetric in form. Either the health community or the social services community have the essential authority; the services of the other area can be ancillary and spasmodic. Is it possible, or even desirable, to have a condition of true reciprocity in the interagency agreements or in the local social service units between health and social services? The developing service systems under IDEA will have to demonstrate how such reciprocity can work.

II. From Present to Future Goals

One of the greatest challenges to leadership is how to facilitate change. Once the decision is made about how to implement the vision of a comprehensive service system that will provide effective services for infants and children with disabilities, the challenge becomes to determine the steps

necessary to move from the current system or enterprise to the new vision. In many instances, this will mean bringing together diverse fragments of efforts from various disciplines and service systems into a more integrated whole. Some strategies that have been tried in the past have been documented and provide some landmarks for approaching this goal. One of the approaches that can be used to implement the vision is based upon Exchange Theory.

Exchange theory has, at its core, a model of reciprocity where one of the involved parties offers goods, services, money, etc., to the other party in exchange for something they value. Scarcity of resources may be a driving force towards exchange, as will the perception that the gains from the linkage will exceed the losses (Oliver, 1990).

As Oliver has stated, the necessity for compliance with legal or regulatory requirements is sufficient reason for an organization to establish Interorganizational Relations (IOR), although, in the case of Part H, it remains unclear exactly what these organizations are committing themselves to. The position of reciprocity, if it can be maintained, carries with it the expectation of equitable contributions by members, equitable allocation of resources, balanced bargaining positions between participants, and low probability of sacrifices of autonomy.

The opposite characteristic to reciprocity is that of asymmetry, a contingency where there is the potential for one agency or organization to exercise power or control over another. If this is the pattern to be expected in Part H collaborations, then some serious problems can be expected from the dominant-dependent role that such asymmetry implies, but that is hardly the expectation of the partners involved. This concern for multidisciplinary cooperation is particularly true in view of the resentment felt by many non-health personnel regarding the dominant position of the medical profession in such interprofessional activities in the past (DiStefano, 1984).

Most of the studies now completed on interorganizational coordination have restricted themselves to institutions within the health profession (e.g., a consortium of hospitals) but the problems identified in such intra-health studies would almost certainly be magnified when taken into these other non-health disciplines (Sofaer & Myrtle, 1991; Provan, 1984).

The development of effective collaborative arrangements or alliances depends upon a number of variables. These variables will need attention if a serious effort is to be made to bring together health services with the major service systems of education and social services. Although the study of organizational systems is still in an early stage of evolution (Schermerhorn, 1981; Morrison, 1992), there have been some determinants of effective alliances of which Part H planners need to be cognizant. Van de Ven (1976) has pointed to an array of variables that can be clustered into situational factors, process dimensions, structural dimensions, and outcome dimensions.

Kaluzny (1991) draws an interesting analogy–that of strategic alliances being akin to operating a sailboat rather than a powerboat. Operating a sailboat depends on teamwork, as does the strategic alliance among a loosely-

connected group of organizations and providers. The sailboat must take advantage of winds and currents to reach its destination, unlike the power boat, which can depend on the power of the motor to reach a destination. The powerboat is reflective of some strong central authority that can dominate others and force their wishes upon them. Clearly, Part H, with its deliberate distribution of power, requires the sailboat approach.

Schopler (1987) has identified four different types of interorganizational group relationships, depending upon (a) whether the groups were mandated to exist or not and (b) whether the tasks and procedures are clearly fixed or not. Part H would probably fit into Type II of Schopler's scheme–"Mandated with Low Task Structure"–since the interdisciplinary approach is mandated in law and regulations, but the specification of tasks to be accomplished is to be determined by the inter-group decision making at the state and local level. Under this model, Schopler would predict: Low/moderate level of problems in group decision making, confusion and covert conflict, a low/moderate member satisfaction, minimal/moderate quality of output, and high/moderate compliance to external demands. The movement from the current status to the new vision of Part H would not be overwhelmingly difficult, by the Schopler standards.

Compare this approach with the "mandated with high task structure" option, which would mean, in effect, the federal government would give detailed directions to the states as to how they would execute this law. The low task structure provides the policy flexibility that the diversity of clients, treatments, and settings would seem to require.

III. The Garnering of Resources

The third part of the vision implementation model is the need for a clear and practical set of strategies by which appropriate resources are obtained for the new vision. The failure to accomplish this third component will leave the vision in the category of an unrealized dream. While financial resources are clearly high on the list of those necessities without which a comprehensive program cannot be established, there are other necessary resources to consider as well. One such consideration must be the availability of competent personnel to provide services. Even an overabundance of financial resources will be of little purpose if services are not provided by personnel judged to be capable in their discipline and able to work in a cooperative mode with other disciplines (Coleman & Gallagher, 1989).

In Part H, the states are asked to review the variety of sources for possible financial support for this comprehensive system of services (the federal government is providing only planning and development money for the states through Part H of IDEA). Clifford (1991) has reported on six case study states and their diverse ways of funding Part H programs. He indicated that while many states have found multiple funding sources for the program, the states might be better off concentrating on only a few sources, because of the complexity of accessing many of these funds.

One of the strategies for securing financial support that has been fixed upon by many state observers and workers has been Medicaid and the EPSDT

(Early Periodic Screening, Diagnosis, and Treatment) program, which has become a part of the Medicaid program (Clifford, Bernier, & Harbin, 1992). As of April 1, 1990, states were required to extend Medicaid eligibility to all children up to age six, in families with incomes below 133% of poverty. This provision theoretically adds about 1.75 million children as eligible under Medicaid. The advantage of Medicaid is that it operates as an entitlement and therefore mandates services to all eligible children, regardless of the presumed availability of funds at state and federal levels of government. If the federal or state government is financially impoverished, it is expected to borrow money or sell assets. It cannot plead governmental poverty as an excuse for withholding governmental services.

The disadvantage of Medicaid is that it has generated much attention as one of the "runaway" entitlement programs of the federal government. Because states are compelled to match the federal funds with state funds in Medicaid, there is a built in uncertainty to the state budget, the mandate provision, which worries many state decision makers and planners. There appear to be few alternatives to this source of financial support, since states seem to be in a difficult funding situation from which they are unlikely to recover very soon.

A recent analysis of private and public health insurance (Fox, Wicks, McManus, & Newacheck, 1992) concluded that the Health portion of the Part H program could be covered by insurance:

> Health insurance, especially Medicaid, can provide reimbursement for many, if not all, health-related early intervention services furnished under the Part H program. Such services include assessment and evaluation, home-based mental health and ancillary therapies, center-based mental health and ancillary therapies, therapeutic nursery and day care services, physicians' services, nurses' services, case management and transportation. (p. 119)

Private insurance has played a significant role in the generation of resources for infants and toddlers with handicapping conditions and for their families, but there have been several disadvantages to the use of the private health programs. One of these disadvantages is the lifetime dollar cap that is placed upon the total amount of claims that one person can make on the policy. While a million dollar cap may seem to be very liberal, many severely involved children can run through that amount before they are even scheduled to enter school. Another serious problem is illustrated by anecdotal reports that parents of severely involved children have trouble obtaining jobs because of the health care expenses that would have to be assumed by the industry (Newacheck, 1990).

Offsetting the advantage of Medicaid being an entitlement is the problem that it may soon be targeted for some type of limitation by the federal government–which is now interested in controlling entitlement programs. Also, Medicaid benefits vary considerably from state to state in terms of what services are available or the level of reimbursement allowed; this has turned off many

physicians, who feel that the increased Medicaid paperwork is not worth the reduced fees they must accept.

The Stabilization of Changes

How does one solidify change? There is a strong case to be made that the forces of inertia will eventually force changes (e.g., family empowerment) back toward a more familiar model of service delivery, the one that it was designed to replace (Tushman & Romanelli, 1985). One seeming necessity for the maintenance of change is the development of new structures.

Such structural change will require a change in the execution of various processes such as indicated in Figure 1. If our changes are revolutionary, then we should expect to see a change in the grounding assumptions that lie at the base of service programs. For example, a new grounding assumption could be that effective programs for infants and toddlers with disabilities and their families require the mobilization of a multidisciplinary team that will diagnose, plan, and execute a cross-disciplinary treatment program integrated through a service coordinator.

Whether this is a defensible proposition for this entire target group, or for a subset of the total group, may well remain in doubt, but it seems certain that Part H does imply such a grounding assumption and that, in turn, requires various structural changes in order to produce the comprehensive, interagency, multidisciplinary service program, as required by the law.

No matter what organization is involved–a state agency, a department in a university or a school system, or a clinic–various suggestions or mandates for change can often be reinterpreted in ways more similar to the status quo. Two state agencies may enter into an interagency agreement which would, in essence, allow them to continue with their business as usual but with a document they could display to satisfy the state or federal government that they are satisfying the requirement for interagency cooperation. Mandates for interdisciplinary training programs can be reinterpreted to mean that two departments in a higher education setting might wish to be involved, but each would operate separate from one another and would not change their basic approach to personnel preparation.

Structural Change. There is a wide variety of devices used to try to enhance the implementation of new policy related to interorganizational relationships. One such device is to provide for formal agreements between the various parties. These agreements can be informal between good friends, but they are more likely to be something like an interagency agreement specifying clearly the responsibilities of each party (Harbin & Terry, 1991). Such agreements are usually time-bound and limited to rather specific actions (Whetten, 1981).

Another strategy is to create some time-bound organization such as a task force or study group that has specific goals and time limits. These organizations allow for reciprocity that can provide a track record of cooperation that can be documented. The "task force" approach has been recognized as a

device to maintain the status quo while getting a specific job done (Luke, Begun & Pointer, 1989). A more definitive change would be to establish a structure that would be assumed to be permanent and would reflect the intention for making long-term shifts in orientation. A higher education-approved joint program on interdisciplinary personnel preparation would be a specific example of a more permanent move than establishing a task force or an interagency committee.

One of the propositions related to organizational change is that most suggested changes will tend to regress back to the status quo if the change that is suggested is less than revolutionary, or unless it occurs in an atmosphere of severe crisis (Gersick, 1990). In an attempt to solidify cooperation on personnel preparation between higher education and state agencies, for example, it may be necessary to establish a consortium with the responsibility of designing a state-wide planning effort on personnel preparation (Rooney, Gallagher, & Fullagar, 1992).

One governor, in order to assure that children's issues would receive consistent budget attention in that state, established a Children's Budget–another structural change–which broke down the overall state budget into specific expenditures for children and established a state-wide Council for Children to provide continuing advice and guidance for state decision-makers on issues related to children. The mandate in Part H for an Interagency Coordinating Council is another recognition of the importance of structural change. The establishment of cross-discipline research institutes and centers in institutions of higher education to study issues such as population control, mental retardation, or early childhood is one more attempt to establish and maintain change through the development of new structures that, in turn, hire new personnel loyal to the new concept rather than to older, established programs.

It seems likely that the systematic collaboration of various disciplines to the specific interest of infants and toddlers with disabilities and their families will require a similar form of structural change and modification. The requirement of an IFSP is one type of structural change, but it would seem necessary to establish something that has a physical presence for the collaboration patterns to be maintained and to not slip back into the established professional-consultant relationship between disciplines that is currently the mode.

Another structural change, some type of community family service center with a core of physicians, psychologists, social workers, and educators, would be one model worth trying. Other ancillary disciplines, such as occupational therapy or early childhood specialists, could be summoned on individual cases where their specialties are particularly required. Such a family clinic would have the Part H population as one significant element of their clientele, but would not be limited to that age group or set of problems. Health Maintenance Organizations could be seen as one variation on such a scheme.

An alternative service structure could be a system of home-based care depending upon teams of professionals coming to the homes of families and providing assistance on site. Such a service system with an identifiable

program and position in the bureaucracy can give a diverse delivery system some structural stability. The financing of such a center or home-based system would have to come from a variety of sources, although medicaid would seem to be one major source and private insurance funds another (see Fox, et al, 1992). In order to stabilize its operation, it might be necessary to have some core funding support from state or local funds (Clifford, 1991). A family center might administer HeadStart programs, provide for family counseling, conduct day care services (including integrative day care services for children with disabilities), provide continuing multidisciplinary services for public schools, etc.

Just as diversity between states foreclosed the federal government from writing a single set of rules by which the states would implement Part H, so the diversity of communities within a state requires a variety of visions of comprehensive service systems. It is critically important that such systems are documented and assessed for their utility and effectiveness.

Part H of IDEA represents not only an effort to provide additional services for infants and toddlers with disabilities and for their families, but also an adventure in the reform of how professional services should be delivered. The extent to which this law actually changes the landscape of the professions, (is it revolutionary or evolutionary?) and the professionals' relationships with families, remains to be determined.

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